13 – 17 Years Old AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

Vision Chart Exam				Audiometry		Menses	Allergies:			B/P	Temp:	Pulse:	Resp:
OD	OS	OU	☐ Unable to perform	☐ WNL	☐ Abnl	☐ yes ☐ no							
Corrected ☐ yes ☐ no				☐ Unable to perform		Menarche	LMP	Wt:	%	BMI:	%	Ht:	%
Medications:													

Parent/Patient Concerns/History:

HEALTH RISK ASSESSMENT: ☐ HEADDSS ☐ GAPS ☐ Other

DENTAL SCREENING: [X] **INDICATES GUIDANCE GIVEN:** ☐ Brushing 2x /Flossing daily ☐ Dental appointment ☐ White spots on teeth

NUTRITIONAL SCREEN: [X] **INDICATES GUIDANCE GIVEN: :** ☐ Nutritionally balanced diet ☐ Junk food ☐ Soda/Juice ☐ Over weight ☐ Activity ☐ Supplements

DEVELOPMENTAL SCREEN: [X] **INDICATES ACCOMPLISHMENTS:** Middle Adolescence: ☐ School attendance ☐ Reading at grade level ☐ Dating ☐ Sexuality/orientation ☐ Risk taking (Learning to drive 15 to 17 years) ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] **INDICATES GUIDANCE GIVEN:** ☐ Sports/injury prevention ☐ Drowning/sun safety ☐ Nutrition/exercise ☐ Safe at Home ☐ Seat belt/air bags ☐ Sex education/STD/resources ☐ Self control ☐ Peer refusal skills ☐ Bullying ☐ Violence prevention/gun safety ☐ Depression/anxiety ☐ Tobacco/alcohol/drugs/Rx drugs/inhalants ☐ Education goals/activities ☐ Social interaction ☐ Sexual orientation/dating ☐ Risks of tattoos/ piercing ☐ Availability of family planning services ☐ After school activities/supervision ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] **INDICATES OBSERVED BY CLINICIAN/PARENT REPORT:** ☐ Comfortable body image ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary **Tanner stage_____**		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN & FOLLOW UP

LABS ORDERED: [X] **INDICATES ORDERED** ☐ Hgb/Hct ☐ U/A **(preferred at 16 yrs)** ☐ Lipid Profile ☐ TB skin test (if at risk) ☐ Other

IMMUNIZATIONS: [X] **INDICATES ORDERED** ☐ Pt. Needs immunization today ☐ Delayed ☐ Deferred ☐ Hepatitis A ☐ MMR ☐ Varicella ☐ Hepatitis B ☐ Tdap ☐ Influenza ☐ Meningococcal ☐ HPV ☐ IPV ☐ Td ☐ Other

REFERRALS: [X] **INDICATES REFERRED** ☐ CRS ☐ WIC ☐ DDD ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ Developmental ☐ Behavioral ☐ Dental ☐ Specialty

Date/Time Clinician name (print) Clinician Signature See Additional Supervisory note ☐**Yes** ☐**No**